

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

ORTHOPEDICS

Orthopedic Surgery Procedures:

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of orthopedic surgical procedures which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachments 2A and, depending upon privileges requested, Attachments 2B and 2C)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in orthopedic surgery granted by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in orthopedic surgery, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ **(another field) AND** active participation in examination process leading to certification in orthopedic surgery.

Procedures Requiring Additional Training (Attachment 2C)

I have attached, as Attachment(s) 2C documentary evidence of the required additional training for each of the following procedures, if privileges are requested for these procedures:

- Surgery of the hand
- Arthroscopic surgery of the wrist
 - Ankle arthroscopy
 - Adult ankle and foot reconstruction

Additional Training:

Completion of a specific fellowship in the **requested** procedure(s):

Licensee Name: _____ License Number: _____

OR

Documentation from the program director of an accredited residency training program attesting to the training during residency in the **requested** procedure(s)

plus

Documentation from a privileged physician who has directly observed the applicant's successful performance or participation in the **requested** procedure(s).

3. Record Review/Clinical Observation (Attachment 3 and, depending upon privileges requested, Attachment 3A - in format provided)

References - Names, addresses and specialty, residency or observation only

I am providing, as Attachment 3, the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

A. Reference for Requested Procedure(s) requiring additional training

I am providing, as Attachment 3A, the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s). and whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (Attachment 4A, for each privilege requested - in format provided)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

Licensee Name: _____ License Number: _____

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training.

Requested Privileges

_____	Closed fracture reduction with anesthesia services
_____	Arthroscopic surgery of the knee
_____	Arthroscopic surgery of the shoulder
_____	Arthroscopic surgery of the wrist - requires additional post graduate training
_____	Ganglion removal
_____	Carpal tunnel decompression
_____	Surgery of the hand - requires additional post graduate training
_____	bone graft pertaining to the hand
_____	nerve graft
_____	tendon reconstruction (free graft, staged)
_____	tendon release
_____	tendon repair
_____	tendon fixation
_____	tendon transfers or arthroplasty of large and small joints, including implants
_____	Surgery of the foot - requires additional post graduate training
_____	ankle arthroscopy - Requires additional training
_____	Adult ankle and foot reconstruction - Requires additional training
_____	Other <i>Please specify and provide supporting documentation on a separate page:</i> _____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

Signature and printed name of Applicant

Date

Licensee Name: _____ License Number: _____

Below this line for Administration Use Only

Application Tracking Record:

Initial Receipt Date of Application	_____
Transmittal Date to Outsourcing Entity	_____
Supplemental Information Requested	_____
Supplemental Information Received	_____
Outsourcing Entity Recommendation	_____
Outsourcing Entity Reviewer	_____
Board Committee Review Date	_____
Board Disposition Date	_____

Licensee Name: _____ License Number: _____